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UNITED NATIONS CHILDREN'S FUND
Programme Committee
1993 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Mali

The Executive Director recommends that the Executive Board approve an amount of $20,625,000 from general resources, subject to the availability of funds, and an amount of $22,129,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of Mali for the period 1993-1997.

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* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1993, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/PL.2 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. With a per capita income of US$ 270, Mali is among the 20 poorest countries in the world and its agriculture-based economy renders it very vulnerable to the vagaries of climate. The repeated droughts, which have been particularly severe in the northern regions, and environmental degradation have adversely affected the living conditions of children and women, resulting in food shortages, impoverishment of households, an increasing number of households headed by women as a result of the exodus of husbands in search of employment, an increase in child labour, and rampant urbanization. In addition, the workload of women and children has been further increased by the scarcity of firewood and the drying up of water points.

2. The infant mortality rate (IMR) is estimated at 108 per 1,000 live births and the child mortality rate at 225 per 1,000 live births. Almost 1 in 5, or approximately 85,000, children under the age of five die each year. Approximately 1,000 deliveries per 100,000 births result in the death of the mother. Diarrhoea, malaria and acute respiratory infections (ARI), aggravated by nutritional problems, are the three main causes of child mortality and alone account for more than 40 per cent of the deaths. Next come tetanus and measles. The shortage of basic services (health, education, drinking water, sanitation), the lack of food security and the low income of households largely account for the persistence of these high rates.

3. As elsewhere, acquired immune deficiency syndrome (AIDS) is spreading rapidly. Among high-risk groups, the rate had already reached 1 in 4 in 1987, and it is currently estimated at 60 per cent. In certain African countries, it is estimated that AIDS could bring about a 50 per cent increase in infant mortality between now and the end of the decade. Given that its prevalence is already very high in several neighbouring countries, Mali will certainly be increasingly affected by this problem.

4. Malnutrition is widespread and it is estimated that one third of children under 15 years of age are affected. Severe malnutrition is more common among children between 12 and 23 months (11 per cent). The highest rate of chronic malnutrition is encountered in the regions of Timbuktu, Gao, Kidal and Mopti (31 per cent). For the country as a whole, this rate is as high as 27 per cent in rural areas and remains high in urban areas (20 per cent). Deficiency diseases (diseases due to iodine deficiency, vitamin A deficiency and iron deficiency anaemia) are assuming disturbing proportions, but the incidence varies greatly from one area to another.

5. The literacy rate is 18 per cent. The rate for women as a whole is 11 per cent, falling as low as 5 per cent for women and girls in rural areas.

6. Only 40 per cent of the population of Mali lives within 15 kilometres of a health centre. It is therefore not surprising that fewer than one in four children below the age of one are fully vaccinated. For the same reason, only 15 per cent of pregnant women in Mali make at least one visit to a prenatal

clinic. Deliveries are attended by midwives in 16 per cent of cases and the same low rate is reflected in anti-tetanus coverage of women of child-bearing age, which is around 10 per cent for the country as a whole. Family planning activities reach only one in a hundred girls and women of child-bearing age and the monitoring of the growth of children under the age of four covers less than 1 per cent. Household budgets have to cover almost 60 per cent of the recurrent health-service costs, the remaining 40 per cent being covered by the State budget and, in particular, by donors.

7. With regard to water and sanitation, the average rate of access to water country-wide is 48 per cent. This figure conceals marked disparities between the regions (between 4 and 60 per cent), those in the north, where the terrain is much more difficult, being by far the worst served. It is estimated that the overall rate of access to sanitation facilities is approximately 15 per cent. Much remains to be done in improving the storage and utilization of water.

8. The primary school attendance rate is 28 per cent of children aged between 7 and 12 years of age, boys outnumbering girls nearly two to one. The figures show considerable differences between, on the one hand, the overall school attendance rate - which is 89 per cent in the Bamako district as against 19 per cent in the Kayes region - and, on the other, the school attendance rate of girls - which is 79 per cent in Bamako, as against 12 per cent in Mopti. Generally speaking, these are disparities within a single region, depending on whether an area is rural or urban. The reasons put forward for the low enrolment rates are the traditional ones of the irrelevance of the school curricula for rural areas and socio-cultural factors. It is these latter, inter alia, which militate against the school attendance of girls.

9. The position of women is largely determined by their excessive workload (household and agricultural duties), multiple pregnancies and traditional status. The productivity of women remains low as a result of the lack of training and access to credit, and this, in turn, reinforces their traditional status.

10. There are considerable regional disparities in terms of the availability of basic services, which are more thinly spread in the Sahelian zone. The low level of development of the country's resources and the socio-cultural constraints constitute additional obstacles to the solution of problems affecting children and women.

11. In a context of structural adjustment, the shortage of these basic services cannot be solved by the State alone. The restructuring of the public service and the privatization of public enterprises directly affect these services, even though it often happens that the enterprises are taken over by the communities. At the socio-political level, the aspiration of the people for a pluralistic democratic system and the deterioration of living conditions gave rise in March 1991 to a popular uprising and to the adoption of a new Constitution, which, following the election of a multi-party Government,

institutionalized the decentralization and devolution of the country's bureaucracy. Thus, the gradual disengagement of the State will be counterbalanced by the increased involvement of civilian society in the administration of its own welfare.

12. The Government of Mali was a co-President of the World Summit for Children and has ratified the Convention on the Rights of the Child. A national plan of action (NPA) for the survival, protection and development of children was prepared and adopted by the Council of Ministers of the interim Government in October 1991.

Primary objectives of the national plan of action

		1990	2000
1.	IMR (per 1,000 live births)	108	72
	U5MR (per 1,000 live births)	225	120
2.	MMR (per 100,000 live births)	1 000	500
3.	Moderate and severe malnutrition in children under 5 (per cent) (underweight)	33	22
4.	Access to safe drinking water (per cent)	48	72
5.	Access to sanitary means of excreta disposal (per cent)	15	30
6.	Basic education		
	Primary enrolment ratio (per cent)	23	46
	Percentage of children enrolled in the first year who complete the primary level	15	30
7.	Adult literacy rate (per cent)	19	50

PROGRAMME COOPERATION, 1988-1993

13. The elaboration of the cooperation programme for 1988-1993 drew heavily on the experience of the emergency assistance operations. The strategies adopted underscored the importance of sustained activities. The programme was executed by a set of projects managed through public and community agencies at the central, regional, district (cercle) and subdistrict (arrondissement) levels.

14. Health, the main programme area, comprised four components: the expanded programme on immunization (EPI), the enhancement of maternal and child health

services (MCH), the diarrhoeal diseases control (CDD) programme and decentralized health programming in the Djenné district. The first three components were intended to provide support for centrally-managed government departments. The experience acquired at Djenné was used to test the health planning and decentralized management model patterned after the Bamako Initiative.

15. Programming in the Djenné district was based on a health development plan for Djenné which integrated all social and health activities with budgeting of investment and operating costs. A new system of management was set up to permit the health centres to finance their activities partly from village financial contributions and partly from State subsidies. A system of charges for the services provided was introduced. The availability of essential drugs and an improvement in the quality of services led to a significant increase in the number of people using the health centres. The concept of cost recovery was found to be both feasible and acceptable.

16. On the basis of experiences such as that at Djenné, the Government has adopted a new health policy based on the integration of the different health services, hitherto too centralized. This policy envisages the establishment of community health centres which are fully funded by the communities but receive technical support from the health services. From 1990 on, UNICEF has reoriented its activities in line with this new policy and assigned primary health care (PHC) advisers to five regions. The rural health/population/water supply project was initiated with joint technical assistance from the World Bank, UNICEF, the United Nations Fund for Population Activities (UNFPA), the United States Agency for International Development (USAID), the European Development Fund (EDF), the French Fund for Aid and Cooperation (FAC) and the German Agency for Technical Cooperation (GTZ).

17. The expanded programme on immunization (EPI) was initiated in Mali at the end of 1986. There were obvious problems in sustaining such a programme in a country with a very poor infrastructure. The objective of attaining nationwide coverage as quickly as possible had resulted in a programme characterized by centralized management which made it more difficult to sustain. Moreover, it was realized that coverage could not be expanded any further. The decentralization of management initiated in 1991 resulted in substantial savings in operating costs. The local development committees took over the funding of certain categories of health personnel in order to increase the rate of immunization. That development helped to consolidate and expand measles immunization coverage from 3 per cent in 1987 to 39 per cent in 1991.

18. The reinforcement of MCH services was aimed at expanding coverage and improving the quality of services provided. To that end, some reorganization took place, mainly at the level of the district health centres. On the other hand, very few health centres at the subdistrict level were included in this exercise and this limited its impact. The new health policy placed the programme in a wider framework in order to create conditions propitious to the implementation of its activities.

19. The CDD programme established a unit for the production of packets of oral rehydration salts (ORS) of satisfactory quality. A study carried out in 1992 has shown that there were more of these packets available in regions where an essential drugs and decentralized planning policy had been introduced. Forty-one per cent of mothers use oral rehydration, 26 per cent in the form of ORS and 15 per cent in the form of a salt-sugar solution.

20. In the Sahelian zones where it was difficult for communities to have access to drinking water, UNICEF has improved the water purification system to make the water drinkable. Since 1989, 261 new wells have been sunk, 214 of them equipped with manual pumps purchased with contributions from the communities concerned. A private maintenance and repair network covering 1,300 pumps has been set up. The hygiene and sanitation component was initiated slowly, pending clarification of Government policy in this area. In 1991, in collaboration with the Government and the United Nations Development Programme (UNDP), UNICEF financed a study which proposed solutions to the problems of hygiene and sanitation in rural areas. The same year, UNICEF financed a national survey on dracontiasis. The disease was found to be endemic to 1,730 of the more than 8,000 villages covered by this survey. A nationwide programme to eradicate the disease was launched in late 1992.

21. In order to arrest the decline in the rates of primary school attendance, UNICEF, in collaboration with the Government, designed more appropriate curricula, especially in the area of health education. This latter project was tested in the Sahelian zone. The identification and implementation of an active goal-oriented teaching methodology, the design and production of teaching materials and the training of teachers are achievements which the Government integrated into the official teaching programmes in 1992.

22. The women's literacy project in the Sahelian zone was based on basic training in the national languages, reinforced by and integrated into community development projects. It has been noted that many children who are not enrolled in school attend the classes given at the project's literacy centres. This phenomenon is all the more remarkable in that the project was being carried out in areas where there was a very strong socio-cultural bias against the school enrolment of children. This experience has led the Government to develop a new programme, based on the women's literacy project, for these children who are not enrolled in school.

23. Family food security projects, which were basically the outcome of the emergency assistance programme, were executed in the Sahelian zone around Timbuktu, Bourem, Djenné and Ségou. In addition to improving the availability of food, these area-based projects also served as focal points for PHC, water supply and women's literacy projects. An ecological component was added in order to promote reforestation. A system managed directly by the communities was used to monitor nutrition among children. The Ségou project was, in effect, a joint nutrition support programme financed by the Italian Government through UNICEF and the World Health Organization (WHO). An external evaluation carried out in 1992 yielded positive results. In particular, the involvement of farmers in decision-making was singled out as a remarkable achievement.

24. The evolution of the situation in urban areas has marginalized an ever-growing segment of the population, the main victims being the street children and the women of the shanty towns. Studies have been undertaken with a view to identifying the problem more accurately. Collaboration has been developed with local non-governmental organizations (NGOs). Thus, the foundation has been laid for the development of a new programme for the period 1993-1997.

25. Communication and social mobilization efforts have focused on the development of a decentralized approach. The programme has devised responses to the immediate and specific needs of each region with regard to EPI, MCH, CDD, environmental sanitation and AIDS. The main obstacle has been the need to integrate the efforts of the various services. However, mobilization efforts with respect to EPI have enhanced awareness and understanding of the programme among virtually all segments of the population, including men. Since 1991, a pluralist private press and free radio stations have been established. The first steps have been taken towards establishing close collaboration with the mass media.

26. The programme on the monitoring of the situation of children and women has enabled the National Statistics and Data Processing Department to prepare a bulletin disseminating specific data on target groups. This exercise has shown the unreliability of the data generated by the technical departments. Thus, the formulation of the national plan of action (NPA) has once again emphasized the need to monitor the situation of children and women. An inter-ministerial committee has been established to devise machinery for the operational follow-up of indicators.

27. A number of points from the previous cooperation programme which were raised during the mid-term review and which resulted in adjustments to the programme in the course of its execution are worth mentioning. The experience acquired has highlighted the effectiveness of the decentralized planning of basic services and the importance of financial or organizational contributions from beneficiaries to the implementation of programmes. The need for greater operational integration among the various sectoral activities has been increasingly felt. Greater account should also be taken of structural adjustment in planning the contribution of the Government to the cooperation programme.

RECOMMENDED PROGRAMME COOPERATION 1993-1997

General resources: $20,625,000
Supplementary funds: $22,129,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	6 084	7 396	13 480
Water supply and environmental sanitation	1 855	4 447	6 302
Nutrition	2 680	4 286	6 966
Education	2 681	2 500	5 181
Early childhood development	1 030	1 500	2 530
Campaign against AIDS	500	500	1 000
Social mobilization and advocacy	1 030	1 500	2 530
Planning/social statistics	225	-	225
Programme support	4 540	-	4 540
Total	20 625	22 129	42 754

a/ The breakdown for estimated yearly expenditure is given in table 3.

b/ In addition, there are also funded supplementary funding projects in table 3.

28. The new cooperation programme is based, for the most part, on an analysis of the current situation of women and children, and takes into account the results and recommendations of the mid-term review conducted in March 1991. The new analysis was prepared by six inter-ministerial working groups. Their work culminated in a national workshop, held in January 1992, to which other United Nations agencies and various NGOs were invited. Since then, the Government and UNICEF have embarked on the formulation of a new cooperation programme. The first phase involved devising a strategy that would set forth the principal programme areas and sectoral approaches. The development of a

master plan and sectoral operational plans followed; this phase concluded with a meeting to review progress, held in July 1992. UNICEF and the Government have worked closely together throughout this process. The various meetings have encouraged exchanges of views between technical departments and other development partners. This series of meetings made it possible not only to better define coordination between the various agencies concerned, but also, and above all, to submit the proposals to the critical appraisal of all those involved.

29. The new cooperation programme takes into account the experience and evolution of the previous programme, during the course of which adjustments were made with a view to optimizing resources and programme impact and responding more effectively to the profound changes in the socio-political situation. These adjustments, which are features of the new programme, also correspond to the recommendations made in the UNICEF programme evaluation conducted jointly in Mali and five other countries by the Australian, Canadian, Danish and Swiss Governments. The evaluation team visited Mali during November 1991 and March 1992.

30. The analysis conducted in 1992 found that the health problems of children and women were the most severe, and ascribed them to dietary deficiencies and to the inadequacy of health structures. Other factors, such as malnutrition, poor hygiene and inadequate education, significantly contribute to these health problems.

31. The aim of the programme for 1993-1997 is to make decisive progress in the reduction of the infant and child mortality rates, so as to attain a rate of 72 and 120 per 1,000 live births, respectively, by the year 2000. It also aims to bring about a significant reduction in the maternal mortality rate (MMR). These objectives will be achieved through eight intersectoral programmes, the impact of which will be mutually reinforcing, and through the activities of other participants, such as United Nations agencies, donors and NGOs.

32. The priority to be assigned to the health sector will govern operational choices at the geographical level. In view of the importance of this sector, health activities will be carried out in all regions of the country, in collaboration with, and with complementary assistance from, the other partners - especially those involved in the rural health/population/water supply project - and several NGOs.

33. With a view to expanding health coverage (geographical and financial accessibility, availability of services), health services will be strengthened and developed within the framework of the Government's new sectoral policy, which aims to boost PHC. The pyramidal health model should evolve away from a hierarchical management concept and towards a more functional concept which would differentiate between levels of operation, support and orientation. The district, which represents the operational level, is the unit responsible for planning, budgeting, and managing health development.

34. Despite the limited purchasing power of these communities, their participation will be essential to the management of the basic health-care system and will thus help to ensure its durability, following the strategy set out in the Bamako Initiative, which advocates the partial funding of health services through contributions from the community towards the purchase of drugs.

35. UNICEF will provide high-level technical support to five regional directorates for the implementation of the programme, which will be co-funded by other donors. The aim of the programme is to create or rehabilitate 120 community health centres, revitalize 27 subdistrict health centres and upgrade the technical capacities of 21 district health centres. UNICEF will also provide material and technical assistance, in districts of this region and in districts of the Sikasso region, for the revitalization of 70 additional subdistrict health centres and the creation of 40 community health centres, and will take full responsibility for their funding. A minimum package of curative and preventive care and promotional material will be developed and established in all these health centres, where it will be available to the community. This minimum package will also include essential drugs.

36. The three northern regions not covered by the rural health/population/water supply project will be served by a project proposed by UNICEF and the European Development Fund (EDF), which will adopt a similar approach. Environmental conditions and the dispersal of population groups favour a strategy involving mobility and versatility to supplement the 30 subdistrict health centres to be revitalized.

37. With regard to family planning activities, the rural health/population/water supply project will expand the coverage throughout the country. In line with the new health policy, family planning activities form an integral part of the services offered at all health centres. This component will be supported by USAID.

38. Programmes under centralized management, in particular EPI and CDD, will be gradually integrated into the basic health services at the district, subdistrict and community levels through the minimum package. This development should ensure the continuity of the programme by lowering costs through a more rational use of resources, particularly logistic resources.

39. On the national level, strategies will be devised to reduce the incidence of diseases that are the most frequent causes of death among children and the high maternal mortality rate in Mali. These include strategies to combat malaria, ARI, sexually transmitted diseases (STD) and perinatal problems. Special attention will be paid to the health problems of women. All these activities will be integrated into the minimum package for marginal population groups.

40. The northern regions, where basic services are more limited, will continue to be the priority programme area for water, drainage and education programmes. In the same area, but on a more limited geographical scale,

nutrition and food security activities will serve as an instrument for the integration of all activities. Environmental degradation, the fragility of the economic fabric and the vulnerability of the population of those regions, which were accentuated by the droughts of the 1980s, were important considerations in this choice. These various activities should reinforce activities in the health sector and have a maximum impact on the welfare of women and children.

41. An improvement in conditions of hygiene and clean water supply are crucial factors in lowering the incidence of diseases which kill children. Furthermore, easy access to water supply reduces the workload of women. Better health can only be achieved through new attitudes, practices and knowledge with regard to waste disposal and general hygiene. Health education will thus be the main thrust of the programme. The eradication of dracontiasis will be the primary focus of health education in those areas where it is endemic, since it will illustrate to the population the decisive impact of good hygiene and proper sanitation.

42. Village water supply projects will advocate the use of sound and sustainable approaches within the reach of villagers in order to supply the drinking water needs of rural communities in the Sahelian zone. The supply of essential spare parts for manual pumps will be improved in order to allow UNICEF to disengage progressively. Execution will follow an integrated approach based on the maximum participation of the community, particularly of women, in the planning and implementation of activities, the operation and maintenance of installations and the monitoring and evaluation of their impact.

43. Formal primary schooling, which until now has been the keystone of the Government's strategy to raise the country's literacy level, still does not appear to meet the needs and desires of rural population groups, despite considerable investment by many partners. The enrolment rate in this sector has stagnated, and is even declining, because of such factors as the high birth rate. At the same time, enrolment in medersas (one of the forms of Arab-Islamic private education in Mali) is increasing; the total number of students now represents 20 per cent of the children enrolled in the first cycle of primary school. Primary schooling will, therefore, be strengthened through support to the medersas. The programme will aim at raising the level of teachers, adopting an improved and harmonized curriculum and reinforcing the teaching of French.

44. Non-formal education will be supported through basic education centres which will be accessible to children not enrolled in formal schools and to women between the ages of 16 and 45. These centres will offer a minimum level of basic training designed to prepare young people to enter an apprenticeship and to help adult beneficiaries to function in their environment as agents of development responsible for the health and social and economic welfare of their families and communities. Linkages will be defined between this type of education and formal public education. The project will support the training of leaders, the development of the school curriculum and the production of

teaching materials. Libraries and collections of audio materials will be established in order to provide the tools for continuing education.

45. A non-institutional approach, aimed at the family and the community, will be taken to the promotion, protection and development of the young child. The child as learner, the parents as educators, the family (siblings and grandparents) as an environment for life and learning, and the community as support to the family will be targeted. This concept will help young children to develop more fully: psycho-motor development, nutrition, health care, physical and emotional well-being, and more relationships and stimulation. The project will train and arouse the awareness of parents, educators and local leaders with regard to teaching approaches which promote the rapid awakening of the young child. The introduction of innovative and low-cost activities in community centres will be supported. During the initial phase, the activities will be carried out on a modest scale.

46. Malnutrition, which contributes significantly to infant mortality, is closely linked to the availability of food, the use of foods and the socio-economic situation of families, as well as to such equally important factors as the nutritional knowledge, attitudes and practices of mothers. In regions where the food supply is generally secure, malnutrition is, above all, a result of nutritional practices and the scant attention paid to the nutrition of children, pregnant women and nursing mothers. In the Sahelian zone, however, the basic problem is a lack of food and the means to buy it.

47. UNICEF intervention is proposed at both the central and the peripheral levels. At the central level, the programme will strengthen national capacities with regard to policy formulation and nutritional activities. The emphasis will be on the use of data on the nutritional situation of children and deficiencies in micro-nutrients. At the regional level, integrated community-based activities will be introduced, giving priority to women. Activities will centre on increasing and diversifying food production, health education, literacy, village water supply, and reducing women's working hours and enhancing their value.

48. In urban areas, the need for basic services exceeds the available means. The stagnation of such services in terms of coverage and capacity, as well as impoverishment and unemployment, have had marked negative effects on the living conditions of children and women. A category of marginalized children and women has emerged and its numbers are growing. It is proposed that activities under the programme will be carried out in peri-urban areas, particularly in the Bamako district and the town of Mopti. These activities will be directed towards women and children with a view to promoting and enhancing their current and future role as mothers and heads of families. The activities will be aimed at increasing their ability to meet their own needs and improving their educational and health situation. This should help their integration into society.

49. The prevention of AIDS, a disease which is spreading rapidly and which is always fatal, has become imperative. The strategy is based on a few

established facts. The transmission of the disease is promoted by migration between Mali and certain neighbouring countries where rates of infection are already high. The alarming increase of human immunodeficiency virus (HIV) infection among girls once they reach the 15-19 age group, in comparison with boys in the same age group, and the role of STD are other factors to be taken into account in combating AIDS.

50. UNICEF advocates support to the national programme to combat AIDS in two areas: changes in behaviour among youth in the 10-to-19 age group and the prevention and monitoring of STD. Other areas of the fight against AIDS will be covered by other donors such as UNDP, WHO, USAID, the Canadian International Development Agency and FAC.

51. The objectives of the World Summit for Children and the Convention on the Rights of the Child must be known and supported by decision-makers and the general public. Information on simple measures that can help to reduce infant, child and maternal mortality should be transmitted to communities. These two obligations are reflected in the new cooperation programme by a sectoral advocacy and communication programme.

52. Advocacy will, inter alia, focus on legislation affecting children and women, the National Plan of Action (NPA) and the baby-friendly hospital initiative.

53. Efforts in the communications area will involve improved transmittal of information within sectoral programmes for the benefit of recipients. In order to achieve this, activities relating to training in communications and the production, support and reinforcement of national capacities will be undertaken with a view to mobilizing the community. The promotion of specific aspects is essentially designed to bring about and consolidate a constructive attitude in general, and with regard to certain specific problems, in particular. Effective communications activities will be developed in order to bring about changes among individuals and households with a view to the better utilization and promotion of services.

54. The situation of children and women will be monitored through certain key indicators set forth at the World Summit for Children. The various sectoral programmes should use these indicators as guidelines in order to promote the attainment of the objectives that Mali has set for itself. It will thus be possible to measure the impact of the efforts undertaken. This monitoring will cover the entire national territory. Its principal focus will be the upgrading of regional offices, which until now have merely relayed data to the centre. Their upgrading will provide the services at the peripheral level with immediate access to data in order to monitor their own activities.

55. Since Mali is a country which receives sizeable contributions for development, coordination with other partners (national, international, bilateral and NGOs) in various fields will continue to be essential. Such cooperation will make it possible to maximize the impact of activities, on the one hand, and, on the other, to ensure that the territory is well covered.

56. The scope of the Government's commitment to the attainment of the objectives for the 1990s is reflected in the integration into the Mali-UNICEF cooperation programme and the sectoral programmes of the specific items related to monitoring and evaluation. These items constitute the pilot mechanism of the programmes/projects and specify the indicators to be selected, as well as the frequency and level of observation. Each cross-sectoral programme sets out a schedule for evaluating those aspects which are regarded as pertinent by two parties. The evaluations will permit the appraisal of the strategies, organization, use of material, equipment and funding, methods employed and results obtained in relation to the objectives set and the resources utilized. The results of these evaluations will assist in the preparation of the mid-term review and the evaluation of the cooperation programme. The latter is due to take place towards the end of th fourth year of implementation so that the results can be integrated into the next cooperation programme.

57. The effective integration of different activities, whether undertaken under the Mali-UNICEF cooperation programme or under other programmes, will be facilitated by the decentralized development institutions already in place: the regional and local development committees. These institutions favour local participation by community development technicians and "tons" (traditional village associations). The programme will be aimed particularly at women, not only as beneficiaries, but also as participants and managers. Their involvement will be the best guarantee of achieving the intended impact and sustained results.

58. For its part, UNICEF will manage the 1993-1997 cooperation programme through the Bamako office and four area offices in Gao, Timbuktu, Mopti and Ségou. The staff of the Bamako office is responsible for the central level, while the area offices are responsible for scheduling and monitoring the programmes from the UNICEF side at the regional and peripheral levels. These two components constitute the major support for the programmes. The link between the two levels is essential to ensure coherence between national policies and execution at the decentralized level. The area offices are managed by national professionals. They are already staffed by international Professionals and United Nations volunteers in the areas of health, nutrition and community development.

59. The number of staff at UNICEF's Mali office has, in short, been slightly reduced. It has therefore proved necessary to introduce significant changes regarding the assignment of staff to the various programmes and the allocation of tasks. The social mobilization and communication programme will receive staff reinforcements so that it will be able to respond to the new demands of the programme, resulting mainly from Mali's national plan of action (NPA). Five international posts (a mixture of United Nations professionals and volunteers) have been abolished in favour of national capacity-building.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Mali	(1991 and earlier years)		UNICEF country classification
Under-five mortality rate	225	(1991)	Very high U5MR
Infant mortality rate	108	(1991)	Very high IMR
GNP per capita	$ 280	(1991)	Low GNP
Total population	9.5 Million	(1991)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1991
Births	(Thousands)	283	352	472	487
Infant deaths (under 1)	(Thousands)	54	53	52	53
Under-five deaths	(Thousands)	124	118	110	111
Under-five mortality rate (per 1,000 live births)		380	310	230	225
Infant mortality rate (under 1) (per 1,000 live births)		190	150	110	108

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1987)	Moderate & severe	--	31 a/
	Severe	--	9 a/
Babies with low birth weight (%, 1979/1982-1985)		13	17
% of primary school children reaching final grade (1980/1988)		45	40

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1987)		96/../82	91 / 95 / 82
Prevalence of wasting (%, 1987)		26	16
Prevalence of stunting (%, 1987)		..	34 a/
Daily per capita calorie supply (% of requirements, 1988-1990)		..	96
Food production per capita index (Index 1979-1981=100, 1980/1991)		97	97
Household expenditure (% of total income, 1980-1985)	All food/cereals		57 / 22

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%)			..
Access to health services	Total	..	15
(% of population, 1985)	Urban/rural	.. / ..	.. / ..
Access to safe water	Total	6	41
(% of population, 1980/1990)	Urban/rural	37 / 0	53 / 38
Access to adequate sanitation	Total	..	19
(% of population, 1980/1985)	Urban/rural	79 / ..	90 / 3
Births attended by trained personnel (%, 1987)		..	32
Maternal mortality rate (per 100,000 live births, 1987)		..	2000

Immunization		1981	1985	1990	1991
One-year olds (%) immunized against:	Tuberculosis	19	13	82	68
	DPT	..	2	42	34
	Polio	..	2	42	34
	Measles	..	13	43	39
Pregnant women (%) immunized against:	Tetanus	1	..	31	9

TABLE 1 (continued)

Mali

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%,1980/1990)	Total	27 / 20	24 / 19
	Male	34 / ..	30 / 24
	Female	19 / ..	17 / 14
Secondary enrolment ratio (gross/net) (%, 1980/1990)	Total	9 / ..	.. / ..
	Male	13 / ..	.. / ..
	Female	5 / ..	.. / ..
Adult literacy rate, 15 years & older (%, 1970/1990)	Total	8	32
	Male/female	11 / 4	41 / 24
Radio/television sets (per 1,000 population, 1980/1990)		15 / ..	43 / 1

DEMOGRAPHIC INDICATORS		1970	1980	1990	1991	2000**
Total population	(Millions)	5.5	6.9	9.2	9.5	13
Population aged 0-15 years	(Thousands)	2653	3400	4529	4695	6218
Population aged 0-4 years	(Thousands)	1033	1312	1804	1869	2358
Urban population (% of total)		14	17	19	25	30
Life expectancy at birth (years)	Total	38	41	45	45	49
	Male	36	40	43	44	47
	Female	39	43	47	47	51
Total fertility rate		7.1	7.1	7.1	7.1	6.4
Crude birth rate (per 1,000 population)		51	51	51	51	46
Crude death rate (per 1,000 population)		26	23	20	20	16

		About 1980	Most recent
Contraceptive prevalence rate (%, 1977/1987)		1	5
Population annual growth rate (%, 1965-1980/1980-1991)	Total	2.1	3.0
	Urban	4.9	5.6

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1967-1980/1980-1991)		2.1	-0.1
Inflation rate (%, 1967-1980/1980-1990)		..	3
Population in absolute poverty (%, 1975)	Urban/rural	27 / 48	.. / ..
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure	Health/education	.. / ..	4* / 17*
(% of total expenditure, 1987)	Defence	..	17*
Household expenditure	Health/education	1 / 2	4* / 7*
(% of total income, 1980-1985/1988-1989)			
Official development assistance:	$US millions	267	408
(1980/1991)	As % of GNP	22	17
Debt service (% of goods and services exports, 1980/1990		3	7

a/ Indicates data that differ from the standard definition, or refer to only part of a country.
* UNICEF field office source.
** United Nations Population Division projections based on past and current trends.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988–1993 a/

COUNTRY: MALI
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $18,553,000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	3635	2069	209	125	1471	796	1814	1408	7129	6588	4398	3270	11527	9858
Household food security and nutrition	490	1015	36	37	681	1290	639	1298	1846	1385	3640	14048	5486	15433
Water supply and sanitation	2497	1703	16	106	73	865	812	1332	3398	3285	4006	8685	7404	11970
Education	608	22	144		22		328		1102	1427	22	2001	1124	3428
Community organization and development	1	60					31	41	32		101		133	
Women-centred programme	70		27	35			56		153	150	35	75	188	225
Planning and social statistics	768	9	158		3042		2165	6	6133	5718	15		6148	5718
Emergency	50	206						26	50		232	1679	282	1679
Freight	197	192							197		192		389	
GRAND TOTAL	8316	5276	590	303	5289	2951	5845	4111	20040 b/	18553	12641	29758 c/	32681	48311

GR = General resources.
FSF = Funded supplementary funding.
SF = Supplementary funding, funded and unfunded.

a/ Actual expenditure includes expenditure recorded as of 17 December 1992.

b/ Including allocations from global reserve funds for unfunded supplementary funding programme.

c/ Of this amount, $3,700,000 remains unfunded.

TABLE 3. PLANNED EXPENDITURE, 1993 – 1997

(In thousands of United States dollars)

Country: MALI Period covered: 1993 – 1997	Funding status	1993	1994	1995	1996	1997	Total
Health	GR	1240	1193	1217	1217	1217	6084
	FSF	1854					1854
	NSF	952	2365	1508	1584	987	7396
Household food security and nutrition	GR	536	523	536	548	537	2680
	FSF	714					714
	NSF	286	1000	1000	1000	1000	4286
Water supply and sanitation	GR	371	371	371	371	371	1855
	FSF	303					303
	NSF	1006	1746	1039	509	147	4447
Education	GR	436	600	561	549	535	2681
	NSF	500	500	500	500	500	2500
Young child development	GR	206	206	206	206	206	1030
	NSF	300	300	300	300	300	1500
Aids programme	GR	127	73	100	100	100	500
	NSF	73	127	100	100	100	500
Social mobilization and advocacy	GR	256	206	181	181	206	1030
	NSF	300	300	300	300	300	1500
Planning and social statistics	GR	45	45	45	45	45	225
Programme support	GR	908	908	908	908	908	4540
	FSF	90					90
TOTAL	GR	4125	4125	4125	4125	4125	20625 a/
	FSF	2961					2961
	NSF	3417	6338	4747	4293	3334	22129
GRAND TOTAL		10503	10463	8872	8418	7459	45715

GR = General resources.
FSF = Funded supplementary funding.
NSF = New supplementary funding.

a/ Not including balances of additional general resources allocation $150,000 for education and $640,000 for water supply and sanitation.

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TABLE 4. LINKAGE OF PROGRAMME BUDGET AND STAFFING/STAFF COSTS

MALI

PROGRAMME SECTION/AREAS AND FUNDING SOURCES	PROGRAMME BUDGET 1993-1997 (In thousands of US dollars)				POSTS a/ and b/ EXISTING POSTS						SUBTOTAL			TOTAL POSTS	STAFF COSTS c/ (In thousands of US dollars)		
	GR	FSF	NSF	TOTAL	D2/L3	D1/L4	P/L5	P/L4	P/L3	P/L2	IP	NP	GS		IP	LOCAL	TOTAL
GENERAL RESOURCES																	
Health	6084			6084				4			4		5	9	2580	495	3075
Household food security and nutrition	2680			2680				1			1	1	1	3	645	424	1069
Water supply and sanitation	1855			1855													
Education	2681			2681					1		1		1	2	585	99	684
Young child development	1030			1030													
Aids programme	500			500								1		1		325	325
Advocacy and social mobilization	1030			1030									1	1		128	128
Planning and social statistics	225			225								1	1	2		424	424
Programme support	4540			4540								7	16	23		3859	3859
TOTAL GR	20625			20625				5	1		6	10	25	41	3810	5754	9564
SUPPLEMENTARY FUNDING																	
Health		1854	7396	9250				3			3	1	4	8	1935	751	2686
Household food security and nutrition		714	4286	5000					2		2		3	5	1170	297	1467
Water supply and sanitation		303	4447	4750				1			1	1	2	4	645	523	1168
Education			2500	2500													
Young child development			1500	1500													
Aids programme			500	500													
Advocacy and social mobilization			1500	1500													
Programme support		90		90													
TOTAL SF		2961	22129	25090				4	2		6	2	9	17	3750	1571	5321
TOTAL GR & SF				45715				9	3		12	12	34	58	7560	7325	14885
ADM. AND PROGRAMME SUPPORT BUDGET (Proposed 1994-1995)	Operating costs			883													
	Staffing b/					1	1	1			3	4	12	19	929	1201	2130
GRAND TOTAL (GR + SF + ADM)						1	1	10	3		15	16	46	77			
	Number of posts and staff costs:																
	- At the beginning of previous programme (1988)										15	11	31	57	N/A	N/A	N/A
	- At the beginning of proposed programme (1993)										15	16	46	77	N/A	N/A	N/A
	- At the end of proposed programme (1997) (Indicative only)										16	17	47	80	N/A	N/A	N/A

a/ Each post, regardless of its funding source, supports the country programme as a whole.

b/ The posts are effective as of 1 January 1994.

c/ Project posts are funded for five years and core posts are funded for two years.

Abbreviations: GR = general resources; FSF = funded supplementary funding; NSF = new supplementary funding; SF = supplementary funding; IP = International Professional; NP = National Professional; GS = General Service; ADM = administrative.